Rehabilitation Unit
California Division of Workers' Compensation

RU-105

NOTICE OF TERMINATION OF REHABILITATION SERVICES

Purpose:
To notify the employee of the employer's termination of liability to provide rehabilitation services. It is not to be used for non-feasibility. This notice is not to be used for injuries prior to 1990.

Submitted by:
Claims Administrator to the injured employee and representative.

When submitted:
Within 10 days of the circumstances set forth in LC §4644(a).

Where submitted:
Original of the notice is sent to the employee and a copy to the applicable Rehabilitation Unit district office. The Rehabilitation Unit's venue is the same as the WCAB. If no WCAB case exists, file with a Rehabilitation Unit within the county where the injured employee resides.

Accompanying documents:

- RU-94 for DOI's on or after 1/1/94 where an offer of modified or alternate work has been accepted or rejected.
- Agreed upon plans for represented injured workers whose date of injury is on or after 1/1/94. (See 1994-1999 rules - AR 10126b(3))
- All declination forms and *Notice of Potential Eligibility.*
- A copy of proof of service.

Rehabilitation Unit action:
When the employee objects to the notice of termination, the Rehabilitation Unit will hold a conference or otherwise obtain the employee's reason for objection and issue its decision.

Notes: **Copies of medical or vocational reports are not required to be submitted to the Rehabilitation Unit when filing a copy of the RU-105 on injuries subsequent to 1/1/90.**

All RU-105 Notices must have a "Proof of Service" as required by AR 10131(a). For further information of "Proof of Service" see 8 Cal 10514.

SAVE PRINT CLEAR

NOTICE OF TERMINATION OF VOCATIONAL REHABILITATION SERVICES

Rehabilitation Use Only

Social Security Number	**WCAB Number**	**Rehab Unit Number**

Employee Name (Last) (First) (MI) Date of Birth

Address (Street) (City) (State) (Zip)

Employer Name	**Insurance Company Name; Or, if Self-Insured, Certificate Name**
Address	Adjusting Agency Name (if adjusted)
City, State, Zip	Claims Mailing Address
Date of Injury / **Claim Number**	City, State, Zip Phone No.
Employee Representative	**Employer Representative**
Firm Name	Firm Name
Address	Address Phone No.
City, State, Zip Phone No.	City, State, Zip

Qualified Rehabilitation Representative

Firm Name Representative Name

Address (Street, City, State, Zip) Phone No.

CLOSURE REASONS (Check one box which applies)

- ❒ 1. The employee declines and has signed the RU-107 or RU-107A.
- ❒ 2. The qualified employee completes a vocational rehabilitation plan.
- ❒ 3. The qualified employee unreasonably fails to complete a vocational rehabilitation plan.
- ❒ 4. The employee has not requested vocational rehabilitation within 90 days.
- ❒ 5. The employer offers and the employee accepts/rejects modified work lasting 12 months, even if the employee voluntarily quits prior to the end of the 12 month period. *(Attach RU-94)*
- ❒ 6. The employer offers and the employee accepts/rejects alternative work meeting all of the conditions listed in Labor Code §4644(a)(6). Attach RU-94.
- ❒ 7. The employer offers and the employee accepts a job not meeting criteria of #5 or #6. (*Attach RU-94)*

NOTICE TO EMPLOYEE

If you agree with the above, no further action is required on your part, and we will not be providing vocational rehabilitation services in the future.
If you disagree with our determination that we have no further liability to provide vocational rehabilitation services, you or your representative must submit your written objections and the reasons for them to the Rehabilitation Unit within twenty (20) days of receipt of this Notice. The form to use to make your objection is enclosed. Be sure to send a copy to me. The Rehabilitation Unit will then determine if you are to be given further services. Please send a copy of this Notice, with your objection, to the Rehabilitation Unit located at: (*insert Rehabilitation Unit address)*

If you have any questions about this notice, you may contact me at: _____.

(Voc. Rehab.) §10133.16

Mandatory Format
State of California
DWC Form RU-105 (01/03)

SUMMARY OF SERVICES PROVIDED

Number of weeks of VRMA: (Within the cap) $_____ Total Amount of paid VRMA: (Within the cap) $_____ Total Amount of PD supplement: $_____ Amount Paid for QRR: $_____	**RU-94 Offer** ❒ Modified Job (L.C 4644 (a)(5)) ❒ Alternate Job (L.C. 4644 (a)(6)) ❒ "Other Job" (L.C. 4644 (a)(7)) Did employee RTW? Yes_____ No_____ If Yes, employee's new job title:_____ Wages: $_____ per _____ (Hour/Week/Month)
DOIs on/after 1/1/94 VR initiated before 1/1/98 VR initiated on/after 1/1/94 Phase I: $_____ Phase A: $_____ Phase II: $_____ Phase III: $_____ Phase B $_____ Total Cost of QRR Services: $_____ QRR Name:_____ Total Cost of Other VR Services: $_____ Amt. Withheld for Employee's Attorney (if any) $_____	**Plan Completion** **Plan Type** ❒ Direct Placement ❒ OJT ❒ Training ❒ Self Employment ❒ Modified Job ❒ Alternate Job Employed in Plan Objective: Yes_____ No_____ If Yes, employee's new job title:_____ Wages: $_____ per _____ (Hour/Week/Month)

PROOF OF SERVICE BY MAIL

I am a citizen of the United States and a resident of the County of: _____. I am over the age of eighteen years and not a party to the within matter. My business address is:_____.

On _____, I served the Notice of Termination of Vocational Rehabilitation Services on the parties listed below by placing a true copy thereof enclosed in a sealed envelope with postage fully prepaid, and thereafter deposited in the U.S. Mail at the place so addressed.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed at_____on_____20_____.

_____
Signature

Copies Served On: